Supreme Court, U. S.
FILED
NOV 13 1976
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

October Term, 1976

No. 75-1691

PAUL I. GUEST, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

No. 75-1698

THE WILLIAMSPORT HOSPITAL, ET AL.,

Appellants

v.

F. EMMETT FITZPATRICK, JR., ET AL.,

Appellees

On Appeal from the District Court for the Eastern District of Pennsylvania

Brief for Appellants at No. 75-1698

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INDEX

Page

OPINIONS BELOW 1

JURISDICTION 1

STATUTES, RULES, AND REGULATIONS INVOLVED 2

QUESTIONS PRESENTED 2

STATEMENT 2

SUMMARY OF ARGUMENT 5

ARGUMENT 6

I. A state may not, by statute, require the sale of private hospital services to a private insurer at less than their real cost, including costs of community services for charity patients, bad debts, research, and for operating growth needs 6

II. Act No. 94 of 1975, unconstitutionally takes Appellants' property without just compensation in violation of the Fourteenth Amendment to the United States Constitution by requiring sale of appellants' services below their real cost 12

III. Hospitals are not a rate regulated industry 16

A. Regulation of Pennsylvania Hospitals 16

B. Travelers is distinguishable and in error 19

CONCLUSION 22

TABLE OF CITATIONS 24

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BRIEF FOR APPELLANTS

OPINION BELOW

The opinion and order of the District Court for the Eastern District of Pennsylvania were rendered on February 27, 1976, and are reported at 409 F. Supp. 818 (E.D. Pa. 1976).

JURISDICTION

The order of District Court was entered on February 27, 1976. The Notice of Appeal to this Court was filed in the United States District Court for the Eastern District of Pennsylvania on March 24, 1976. The Jurisdictional Statement was filed in this Court on March 24, 1976, and this Court noted probable jurisdiction on October 4, 1976.

The jurisdiction of this Court is predicated upon 28 U.S.C. §1253.

STATUTES INVOLVED

The statute of the Commonwealth of Pennsylvania herein involved is the Act of August 2, 1974, Act No. 94, 40 Pa. C.S. §6124, et seq., which statute is reproduced in its entirety at page 1 of the Appellants' Jurisdictional Statement Appendix.

QUESTIONS PRESENTED

1. May a state, by statute, require the sale of private hospital services to a private insurer at less than their real cost including costs of community services for charity patients, bad debts, research, and for operating growth needs?

2. Does Act No. 94 of 1974, by requiring sale of hospital services below real cost, unconstitutionally take Appellants' property without just compensation in violation of the Fourteenth Amendment to the United States Constitution?

3. Are hospitals, as opposed to hospital plan corporations, rate regulated industries?

STATEMENT

The Williamsport Hospital and other hospitals represented by The Hospital Association of Pennsylvania are affected by Act No. 94 only by the loss of the right to terminate their Blue Cross contracts on ninety (90) days notice.[1]

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1. Appellants in No. 75–1698 concur in the arguments presented by Appellant to No. 75–1691 and rely upon the issues there presented. In view of the consolidation, we have limited our brief to the issues of confiscation, taking of property without compensation, and the Lower Court's misreliance on *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974).

Act No. 94 has ingrained upon their contracts a period for termination which may take as long as thirteen months, and thus since these contracts, like the Philadelphia contract, are based upon the reasonable cost reimbursement system under the Medicare regulations with various modifications, the thirteen months' extension forces hospitals to receive reimbursement at a lower level than they could receive if they were able to terminate the contract and initiate direct billing to each patient.

Much more important than the time for termination is the effect of this statute in imposing state requirements to continue to serve Blue Cross subscribers at less than the real cost of hospital care. For a variety of reasons, hospitals have been forced to agree to reimbursement from Blue Cross which fails to include their fair share of the cost of community service performed by hospitals.

Hospitals serve four segments of patients which provide revenues which may vary by hospital, but are roughly equal in size. These are Medicare patients, Medicaid patients, Blue Cross subscribers, and self-pay patients. Self-pay patients include those with commercial insurers, and those who pay only part of their bills. Hospital charges are paid only by self-pay patients, and are substantially higher than levels of cost reimbursement for the same services paid by Blue Cross on behalf of its subscriber, sometimes by as much as 40 percent higher. The other three segments pay "reasonable cost" reimbursement as determined under the Medicare formula with some modifications.

In addition to those contributing to hospital revenues, there are patients, treated as charity patients, who make no payments at all, and patients who are not identified as charity patients on admission but who are unable to pay all of their hospital bills and thus become "bad debts". Likewise, under-compensation for ambulatory care under the Medicaid program appears as charity care to the extent of the cost over state reimbursement. These community service costs to hospitals are part of the "real cost" of

operating a hospital, and the record in this case shows that these costs are causing substantial losses in operating most hospitals. Most hospitals are covering these costs by spending their allowance for depreciation to cover the deficit (Williamson Affidavit paragraph 7), while philanthropy, which historically was available as a source to offset losses, has long since been insufficient to cover the costs for community services of hospitals.

Blue Cross, under its subscriber agreements, contracts to provide medical insurance to its subscriber which insurance will cover all, with minor exceptions, costs incurred by a subscriber in receiving health care if the subscriber selects a member hospital. In the event that a subscriber fails to go to a member hospital, Blue Cross only provides benefits at a rate unrelated to the premium that the subscriber paid for the coverage. Typically, Blue Cross will only provide benefits up to $50 per day for the first day of hospitalization and $25 per day thereafter if the patient selects a nonmember hospital. Act No. 94 purports to remedy, under the guise of protecting the health and welfare of Pennsylvania citizens, a crisis in the health industry, which crisis would result if Blue Cross subscribers were unable to receive treatment at member hospitals. This alleged crisis, addressed by Act No. 94, resulted not from the hospitals' refusing to contract with Blue Cross, but rather from Blue Cross' refusal to provide reasonable benefits to its subscribers who received care from a nonmember hospital. If Blue Cross would provide benefits at a nonmember hospital equivalent or nearly equivalent to the pay-out of benefits at a member hospital, this crisis would not have resulted.

Blue Cross sells term insurance to its subscribers, and in its contracts with member hospitals provides that if the contract between the member hospital and Blue Cross is terminated, then a run-out period commences which protects the Blue Cross subscriber who has purchased term insurance which remains in effect. Essentially, the run-out provision guarantees to the Blue Cross subscriber that he

may select the services of a former member hospital even though Blue Cross and the hospital have terminated their contract. It is important to note, that the subscriber, in contracting with Blue Cross, has not prepaid for further coverage at a member hospital after the anniversary date of his policy. If a subscriber renewed with Blue Cross after August of 1974, it was with the full knowledge that the Blue Cross contract with their hospital had been terminated and that the subscriber was only entitled to receive those benefits payable at a nonmember hospital. Accordingly, the statutory declaration contained in Act No. 94 that Blue Cross insurance is prepaid is not supported by the record, nor is it an accurate understanding of the way in which Blue Cross contracts operate.

Finally, it is Appellant's position that since there was no state anti-trust regulation of Blue Cross until the Act of July 22, 1974, P.L. 31, 40 Pa. C.S.A. §1171.1, et. seq., which Act postdates the contracts in question, hospitals are not regulated under Pennsylvania law. Rates of payment from Blue Cross are not subject to rate regulation but only to Insurance Department approval and thus the refusal to permit hospitals the real cost of rendering care cannot be justified as part of a system of rate regulation. Accordingly, Act No. 94 cannot be justified as filling the gaps in a regulatory scheme, which does not exist.

SUMMARY OF ARGUMENT

The Medicare "reasonable cost" reimbursement formula which pays only for patients within the program in "taking care of their own" is partially justified for Medicare and Medicaid but is inappropriate for Blue Cross. Medicare includes all over 65 years of age and Medicaid pays for indigents. Blue Cross subscribers are the bulk and the backbone of the economy of the community. Community services rendered by hospitals should be paid proportionately by Blue Cross subscribers as a matter of public policy.

Care is required for those unable to pay not covered by the state determined levels for Medicaid and for those able only to partially pay—"bad debts". This care is most of the community service of hospitals. The cost of this care is a "real cost" of operating a hospital. If "real cost" is accepted as cost, Act No. 94 requires hospitals to operate at less than cost if no contract is finally agreed upon.

A state requirement to operate at less than cost is a taking of property without just compensation in violation of the Fourteenth Amendment of the Constitution of the United States.

The loss of the right to terminate a Blue Cross contract by a member hospital as provided in Act No. 94 of 1975 which results in a confiscatory taking of its property, is a loss of a substantive contractual right which violates the Contract Clause.

Act No. 94 violates both of these Constitutional provisions and the order of the lower court should be reversed.

ARGUMENT

I. A STATE MAY NOT, BY STATUTE, REQUIRE THE SALE OF PRIVATE HOSPITAL SERVICES TO A PRIVATE INSURER AT LESS THAN THEIR REAL COST, INCLUDING COSTS OF COMMUNITY SERVICES FOR CHARITY PATIENTS, BAD DEBTS, RESEARCH, AND FOR OPERATING GROWTH NEEDS.

Although not specifically addressed by the Lower Court, a resolution of the underlying issue that a hospital is entitled to receive reimbursement at a level to meet its real cost of hospital care is imperative to sustain Appellants' position that Act No. 94 is confiscatory and thus takes property without due process of law.

Ninety-five percent of the hospitals in Pennsylvania and most hospitals across the nation are nonprofit institutions. These hospitals originally were operated as purely charitable institutions catering to the indigent and medically indigent. Historically, hospital revenues were derived

from contributions made by local taxing authorities in the areas in which they resided, endowment income, and a small charge to those who were able to pay. This charge never approximated the actual cost to the hospital of providing its services. *Factors Affecting the Costs of Hospital Care,* edited by John H. Hayes.

Increasingly throughout the twentieth century, hospitals have been recognized as the most appropriate places in which to receive quality medical care. While in earlier times, persons able to pay for medical care received it in their private homes and not in hospitals; today, such practice is obsolete. As the patient load increased and the commensurate advances in medical science and its expansive technology flourished, the original financing sources supporting hospitals have become clearly inadequate. No longer can hospitals rely on the largesse of public and private benefactors supplemented by a charge to patients unrelated to actual cost, if they are to provide high quality care to their patients, and operate in a fiscally sound manner.

During the depression years of the 1930s, a development related to the financing of hospital care occurred with the enactment of the Hospital Plan Corporation Act of 1937, Act of June 21, 1937, P. L. 1948, in Pennsylvania. This Act provided for Blue Cross corporations to provide term insurance for their subscribers to meet the costs of health care and the medical necessity of receiving treatment in hospitals as opposed to private homes. Due to the depression and the inability of persons to financially meet the burdens of health care, Blue Cross was started to provide a community fund from which those in need of medical care could receive that care, and the expense would be spread over a large number of persons.

Initially, when Blue Cross first began, the numbers of persons insured by Blue Cross did not approach its current 50 percent control of the market in Philadelphia. Accordingly, when hospitals agreed to provide preferential treatment to Blue Cross subscribers for the guarantee of

prompt payment, the hospitals were able to give that preferential treatment to Blue Cross subscribers for the guarantee of prompt payment. The hospitals were able to give that preferential treatment while knowing that their costs for bad debts, charity care, and expansion could be spread over the larger number of private-pay patients. A relatively minor increase in costs to the majority of private-pay patients insured that a hospital could receive its actual costs. Even at this earlier time, private-pay patients were subsidizing Blue Cross subscribers.

As Blue Cross' percentage of the prepaid insurance market has increased, there has been a commensurate decrease of the number of persons upon whom a hospital can reasonably expect to shift the burden of paying the hospital its full financial requirements. This development means that whereas, historically it was the responsibility of the entire community to provide the real costs of a hospital through contributions from taxing authorities and endowment income, that community, because Blue Cross provides insurance for the vast majority of the patients, has grown smaller and smaller over the years. Since local taxing authorities and philanthropy no longer provide the substantial contributions required to support a hospital in fulfilling the community responsibility to insure the availability of care to all, the community responsibility must be borne by all those able to pay receiving health care. This manifestly includes Blue Cross subscribers who are members of the community which the hospital serves.

Approximately 75 percent of all hospital services in Pennsylvania, including Blue Cross reimbursement, is based upon a "reasonable cost" reimbursement formula as modified by contract. This reimbursement is predicated upon the statutory theory created in the Medicare program, 42 U.S.C.A. 1395X(v)(1)(A), which provides for reimbursement at reasonable cost. Reasonable cost includes actual cost, excluding any part of incurred cost found to be unnecessary. The regulations are required to provide that ". . . necessary cost of efficiently delivering covered services

to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered and the costs with respect to individuals not so covered will not be borne by such insurance programs. . . ."

This theory of "taking care only of your own" may be appropriate both for Medicare and Medicaid, but is wholly inappropriate for Blue Cross, particularly in a place like Philadelphia, where more than 50 percent of the population are Blue Cross members. This represents a much higher percentage of those able to pay for medical care.

Only 25 percent of all patients pay hospital charges. The rest are covered by Medicare, Medicaid, or Blue Cross. Since the latter three pay only reasonable cost under the Medicare formula, any cost not paid as part of allowable reasonable cost has fallen upon self-paying patients or their commercial insurers who must pay hospital charges. This burden has grown as each organized cost reimbursement program has tightened its rules, so that some hospital charges, to this limited group of private-pay patients, are as much as 40 percent more than cost reimbursement.

Some of the real costs of operating a hospital that are not recognized in the "take care of your own" theory of cost reimbursement are charity patients, bad debts, and the operating growth needs of hospitals. Charity patients are those not eligible for medical assistance who still cannot afford to pay hospital bills. Bad debts arise largely from those who cannot be identified as charity patients on admission who still find it impossible to pay all of their bills. These persons are treated at hospitals as part of their tradition of rendering medical service to those who require help without regard to ability to pay.

This community service, the Lower Court found, was not imposed upon hospitals by Blue Cross patients, with which for the most part we can agree. There is likewise a Hill-Burton[1] commitment by most hospitals to perform such service, but Hill-Burton moneys are invested in bricks

1. 242 U.S.C.A. 291, et seq.

and mortar. There is no commitment by hospitals not to recoup the costs of such service from their patients as part of the real cost of operating the hospital.

Medicare largely takes care of both rich and poor over 65 years of age, and the statutory policy of "taking care of their own" can be at best partially justified on this basis. The throwing off of costs for misutilization or expiration of entitlements under this program burdens other individuals in contradiction of the statutory policy. So will the new cost limits permitted under the most recent amendment of the Medicare Act (October 30, 1972 92–603), but at least to this point these burdens have been bearable.

Medicaid provides for a state-determined class of indigents, if not all those needing medical assistance. It is difficult to argue that this relief program should be burdened by the costs of those for whom the legislature failed to perceive the need. This program likewise throws off costs of misutilization, and until recently expiration of entitlement[2], which must be borne by individuals not covered by Medicaid, but this burden too has to date been found bearable.

It is Blue Cross, with its enrollment of the great bulk of the population able to pay for hospital services, which by adopting the Medicare approach has avoided for its subscribers their fair share of the community services of the hospital. Many Blue Cross subscribers, as group participants, have their premiums paid as fringe benefits by their employers. It is this broad base of Blue Cross members from whom the cost of bearing their fair share of community services must be collected if hospitals are to survive and continue to render service in accordance with the community needs.

Although we have talked of roughly a quarter of the patient population in hospitals being Blue Cross sub-

2. The Act of July 15, 1976 P.L.–(No. 202) amended the Public Welfare Code Act of June 13, 1967, P.L. 31 Article IV §443.1, 62 P.S. 443.1 to eliminate the sixty day benefit period limitation.

scribers and a quarter being self-pay patients, in Philadelphia more than half of the population are subscribers whether in need of hospital services or not and the self-pay patients include all those who turn out to be bad debts.

It becomes a matter of public policy whether by seeking the shield of Blue Cross membership one can shirk the community responsibility of paying for care for the less fortunate. The record in this case discloses that some Pennsylvania Insurance Commissioners, in a misguided attempt to keep Blue Cross subscriber rates down, have opposed "their own" bearing their fair share of these costs. They have eliminated this portion of the real cost of operating a hospital by simply having these costs negotiated as "not allowable" in determining "reasonable costs" by following the Medicare formula.

The ability to persuade Blue Cross to exclude these costs is a far cry from imposing a rate system, or prohibiting the termination of the contract, by state action which requires the hospital to render service at less than their real cost. This is doubly important in hospital financing where half of the revenues are based upon reimbursement at less than real cost in "taking care of their own" for Medicare and Medicaid.

If all segments of the hospital population paid only for "their own", some people would have to go without hospital care. The Court Below seemed to feel this was not at issue in this case. Only by ignoring the need for payment of the real cost of operating hospitals including its community service could the Lower Court ignore the confiscatory aspect of retroactive application of Act No. 94.

The statement of the Lower Court that Blue Cross does not require hospitals to undertake community services and that such services are rendered to meet the standards of the American Hospital Association (No. 75–1698 J.S. p. A21) is to ignore the community need for such services. Blue Cross having captured the great bulk of the community able to pay, cannot so easily shrug off the responsibilities of its subscribers.

This point is well stated by Luongo, J., in his dissenting opinion 409 F. Supp. 818. 828 (1976):

> "The cost formulae adopted in the earlier negotiated contracts do not allow to the hospitals, as reimbursable expenses, most community service activities, including care provided to indigents, writing off uncollectible accounts of patients not insured under a contracting hospital plan corporation, providing charity allowances, and undertaking certain education and research activities. Private paying patients or patients with private insurers have, accordingly, always paid a disproportionate share of such expenses. In earlier years there apparently existed sufficient numbers of such patients, and the hospital plan corporation arrangement had sufficient advantages, to make it financially feasible for the hospitals to enter into such agreements. Under the present arrangement, more individuals will likely become subscriber patients because of the relatively lower premiums the hospital plan corporations can charge, since under Act 94 the hospital plan corporations will pay to the hospitals less than private insurers or self-paying patients will be required to pay. Thus an increasingly higher percentage of the hospitals' patients will not be paying their share of the cost of the hospitals' community service activities."

It is respectfully submitted that Act No. 94 by imposing the Medicare formula on hospitals for a period of thirteen months through state action, is confiscatory in that it fails to return to hospitals the proportionate real cost of operating their institutions. If no contract is finally negotiated, this loss is irrevocable for the hospital.

II. ACT NO. 94 OF 1975, UNCONSTITUTIONALLY TAKES APPELLANTS' PROPERTY WITHOUT JUST COMPENSATION IN VIOLATION OF THE FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION BY REQUIRING SALE OF APPELLANTS' SERVICES BELOW THEIR REAL COST.

Act No. 94, in Section 2 thereof, retroactively reinstates terminated contracts between Hospital Plan Corpo-

rations and contracting hospitals and prohibits hospitals with existing contracts from terminating them in accordance with their terms. Upon reinstatement or upon a desire to terminate, the provisions of Section 1 of the Act, which pertain to the procedure under which contracts may be terminated, become applicable to the contracts.

Section 1 of the Act requires that in order for a contract to be terminated, the parties must provide each other and the Department of Insurance with ninety days' advance written notice. The Insurance Commissioner must then hold public hearings to investigate the termination and, incident thereto, the contract termination is then suspended for up to six months. Following the hearings, the Commissioner makes specific findings as to the dispute and makes recommendations for further negotiations between the parties.

After the Commissioner makes his recommendations, the Act requires the parties to renew negotiations and, incident thereto, the terminated contract is extended an additional period of ninety days. In the event that a settlement is then reached by the parties, the new contract, pursuant to Section 1(a)(5) of the Act, is automatically made retroactive to the date of expiration of the contract previously in effect between the parties.

It is important to note that Act No. 94 does not purport to give the Commissioner the power to impose a contract on the parties. The Commissioner's power is solely to hold hearings and make recommendations. It is true that the Commissioner must approve the contract and the rates agreed to by the parties, 40 Pa. C.S. §6124, but clearly his role is limited, for though he may refuse to approve the contract and thus the negotiated rates contained therein, he may not impose others to his satisfaction.

Secondly, while the Act provides that any negotiated contract shall be retroactive—hospitals thus would not lose any contract benefits by virtue of the extensions to the preexisting contract under the Act—it fails to provide a mechanism for the hospitals to recoup their loss in the event that

a new contract is not negotiated. The burden of absorbing the difference between the hospitals' real costs and the rate of payment under the pre-existing contract, during the statutory extensions, therefore, would be borne only by the hospital which would not have any recourse against the Hospital Plan Corporation. The statutory extensions of the contract and the failure to provide a mechanism for hospitals to receive their real costs, if a new contract is not negotiated, deprive hospitals of their property without just compensation.

Prospectively, the statute is constitutional but it cannot properly be applied to reinstate contracts or to contracts presently in existence.

The Philadelphia contracts were specifically terminated by area hospitals because the Appellee refused to include the real cost of rendering hospital care in their formulas, and the hospitals felt they could no longer continue to operate under a reimbursement formula that failed to include these costs. As the result of the reinstatement, by Act No. 94, of these terminated contracts, hospitals continue to suffer the loss of necessary revenues essential to their fiscal stability, which revenues would not be lost, but for Act No. 94 because the hospitals would be directly billing subscribers. It is not a question of reducing the net rate of return to a profit-making institution, but rather causing the hospital to operate at a loss.

Without conceding that hospitals are a regulated industry, an issue which will be addressed later, this Court's decision, relevant to the right of regulated industries to receive a "reasonable rate of return", and the right of a regulated business not to operate at a loss, are instructive. This Court has uniformly held that an unreasonably low rate of return is confiscatory and violative of due process. *Denver Union Stock Yard Co.* v. *U.S.*, 304 U.S. 470 (1938); *U.S. Rys & Elec. Co.* v. *West*, 280 U.S. 234 (1930); See also, *D.C. Transit System, Inc.* v. *Washington Metropolitan Area Transit Commn.*, 466 F.2d 394 (D.C. Cir. 1972), *cert. den.*, 409 U.S. 1086 (1972).

Although decided under the Contract Clause, Article I, Section 10, of the Constitution, the cases of *W. B. Worthers Co.* v. *Kavanaugh*, 295 U.S. 56 (1935); *Home Building & Loan Assoc.* v. *Blaisdell*, 290 U.S. 398 (1934); and *Louisville Joint Stock Land Bank* v. *Radford*, 295 U.S. 555 (1935), are also instructive as to the constitutional parameters within which the legislature or Congress may enact retrospective statutes.

In both *Kavanaugh and Blaisdell*, this Court construed statutes which retroactively extended the period during which a defaulting mortgagor could redeem property upon which the mortgagee had foreclosed. In sustaining the constitutionality of a Minnesota statute, this Court noted in *Blaisdell* that though the mortgagee was denied physical possession of the premises, it retained, because the mortgagor was required to pay a fair rental to the mortgagee, "the equivalent of possession during the extended period", 398 U.S. at 425. Additionally, the mortgagee was not required to forfeit any deficiency judgment in the event the property was redeemed; and finally, the extension was for a limited period of time. The substantive rights of mortgagees were not impaired in light of the above provisions.

A state statute somewhat similar to that sustained in *Blaisdell*, in that it also extended the redemption period for defaulting mortgagors, was struck down as violative of the contract clause in *Kavanaugh* because that statute effected the substantive rights of the mortgagees. Unlike the provisions of the Minnesota statute sustained in *Blaisdell*, the statute in *Kavanaugh* failed to protect the mortgagee, the defaulting mortgagor was not required to pay rent while he remained in possession, nor was the mortgagor responsible for interest or taxes. The resulting infringement of the mortgagee's rights was substantive as they had to assume the financial burden of the state's largesse.

This Court similarly concluded in *Radford* that a federal law, the Frazier-Lemke Act, failed to pass constitutional muster because it permitted defaulting mortgagors to redeem property at its appraised value regardless

of the amount of the outstanding debt. The substantive rights of mortgagees were impaired, and thus, the statute effectuated a taking of property without just compensation. The demonstrably great public need could not justify this constitutional abridgement.

The confiscatory result of Act No. 94 is analogous to the statutes in question in *Kavanaugh* and *Radford* because the substantive contractual right of a hospital to terminate its contract with Blue Cross, and thus obtain relief from necessary reimbursement below its full financial requirements is impaired without the statute providing for financial relief to hospitals in the event a new contract is not consummated. This result is violative of the Fourteenth Amendment in that a hospital's property, re the services it renders to a patient, is being taken without just compensation. Such a result cannot be condoned on the basis of public policy or on the basis that hospitals are not regulated industries and the Appellants respectfully urge this Court to reverse the decision of the Lower Court.

III. HOSPITALS ARE NOT A RATE REGULATED INDUSTRY

The majority of the Lower Court, in its opinion, does not contend that property is not being taken without just compensation but rather, the majority opinion attempts to justify this taking by saying that hospitals are rate regulated corporations and thus, the state may impose remedial measures regarding the disputed rates, 409 F. Supp. at 825.

The assumption by the majority of the Lower Court that hospitals are rate regulated corporations is at the heart of this controversy and Appellants submit that such a conclusion is emphatically wrong.

A. REGULATION OF PENNSYLVANIA HOSPITALS

Hospitals in Pennsylvania have been subject to supervision by the Department of Welfare for many years, under the Public Welfare Code as first enacted, Act of April 9,

1929, P.L. 177, and codified by the Act of June 13, 1967, P.L. 31 (No. 21), Articles 9 and 10, 62 P.S. §901, et seq. Article 9 dealt with nonprofit hospitals which were defined as "supervised institutions" if they received aid either directly or indirectly from the state. Article 10 provided for licensing of proprietary institutions. Each provided for the creation of minimum standards for the care and treatment of patients and the management of patient conduct and provided a duty of visitation and right of inspection of these institutions to assure that the standards were being met. The authority was transferred as to hospitals under Reorganization Plan No. 2 of 1973, 71 P.S. §755-2, to place this authority in the Department of Health.

Despite the newspaper publicity which the recent Insurance Commissioner, Herbert Denenberg, obtained for his activities in the health care field, the only authority, before the passage of Act No. 94, that he had over hospitals was the approval of contracts between Blue Cross plans and hospitals under the Nonprofit Hospital Plan Act of June 21, 1937, P.L. 1948, now codified by 40 Pa. C.S.A. §6124(a). This Act gave him authority to approve or disapprove all rates of payments to hospitals by hospital plan corporations and all contracts entered into by Blue Cross with its member hospitals. Act No. 94 added to his authority the right to make recommendations and findings as to disputes between Blue Cross and its member hospitals in negotiating a contract, but even Act No. 94 failed to provide the Commissioner a right to set rates.

The regulatory power of the Department of Welfare, now in the Department of Health, certainly failed to make hospitals a regulated industry as that term is used to justify the conclusion of the Lower Court. Hospitals are no more regulated than are restaurants which are required to maintain certain minimal standards of cleanliness in purveying food to the public.

The regulatory power of the Insurance Commissioner is even more limited since the Nonprofit Hospital Plan Corporation Act, Act of November 15, 1972, P.L.—— (No.

271), 40 Pa. C.S.A. §6101, et seq., provides that approval of contracts is to be made in accordance with the procedure for approving certification of hospital plan corporations, 40 Pa. C.S.A. 6124(b), and that procedure, after empowering the Department to establish the form of applications for approval, provides 40 Pa. C.S.A. 6101(d) as the standard for issuance of a certificate of authority (approval) that it "shall be issued by the Department only if and when the Department shall find and determine that the application complies with the provisions of this Chapter and the regulations of the Department thereunder".

It is significant that the Insurance Department in Pennsylvania never promulgated rules for the application for, or approval of, Blue Cross contracts or with respect to the provisions to be contained in Blue Cross contracts with hospitals except for the informal guidelines which had no official status. There also is a provision under 40 Pa. C.S.A. 6102(e) for the Department in granting approval to impose such conditions as it may deem just and reasonable. These conditions, however, must conform to making the application comply with the standards set forth in (d) above.

The only test of the Insurance Commissioner's authority over Blue Cross contracts with hospitals is found in the case of *Pennsylvania Insurance Department* v. *St. Luke's Hospital*, 21 Commonwealth Ct. 10, 342 A.2d 773 (1975), in which the Court held that the refusal of the Commissioner to approve the contract in that case was not such a manifest and flagrant abuse of discretion or purely arbitrary execution of duty as to be reversible on appeal since that Court found that the reasons assigned for disapproval of the contract related to the rates of payment by Blue Cross to hospitals and justified the refusal. At the same time, however, the Court rejected the recommendations and guidelines which had been distributed by the Insurance Commissioner as a basis for refusal to approve the contract. This portion of the finding in that case is of substantial significance since the Commissioner had dis-

tributed to the press and to Blue Cross plans 71 guidelines which he had desired to have incorporated in Blue Cross contracts with its member hospitals. These ranged from matters relating to rates, to provisions for no smoking and the composition of the board of hospitals, and they clearly evidenced an intention on the part of the Insurance Commissioner to exercise the power to regulate hospitals under the Blue Cross contract. This power, except as to approval of rates, was rejected.

It is clear, therefore, that Pennsylvania hospitals are unregulated except as to the standards of treatment which are subject to inspection and recommendations for improvement. Hospitals are entitled to complete control of their charges and must obtain Insurance Department approval only of its rates of payment with Blue Cross. Unfortunately, this has permitted the Insurance Commissioner to review only the revenues flowing from Blue Cross and to ignore the financial requirements of hospitals for the real cost of community care.

The elusive influence of past Insurance Commissioners has prevented hospitals from being able to even challenge the lawfulness of the policies the Commissioner espoused since Blue Cross has refused to agree upon contractual provisions inconsistent with those policies.

There is no rate regulation of hospitals since their rates are not fixed. No agency is responsible for their financial stability. There is no statutory standard for the approval of rates of payment by Blue Cross and thus reasonableness is the only standard. The power to approve without the power to fix rates does not amount to rate regulation.

B. TRAVELERS IS DISTINGUISHABLE AND IN ERROR

The Lower Court clearly relied upon *Travelers Insurance Company* v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1974), as the basis for stating that mandated cost ceilings on reimbursement

and the exclusion from the reimbursement formula of the cost of free care and capital expense had been mandated by the Insurance Department and were proper terms in the contract. The *Travelers* case on which the Court relied is distinguishable from this case and was wrong as a matter of law as to the McCarran-Ferguson[1] Act exemption and is not good authority in this case.

The rights of the Insurance Department with respect to member hospital contracts has been heretofore discussed, and it is clear that the Department had no right to mandate the recited provisions. Whatever contacts Blue Cross may have had with the Insurance Commissioner in this case, it is clear that he did not perform his official function of approving or disapproving, since no contract was ever agreed to. There is no evidence that he mandated the terms of the earlier contracts. The fact that the Court in *Travelers* misinterpreted the actions of the Insurance Commissioner as mandating terms in the contract certainly cannot be used against the Appellants in this case.

Travelers is completely inapposite. The suit was by a commercial insurer, and the hospitals supported Blue Cross. On the hearing on coercion, no evidence was produced to sustain that charge. That certainly is no basis for refusing a hearing in this case to prove the confiscatory nature of paying less than real cost.

Appellants contend that not only is *Travelers* distinguishable, but in addition, that the application of the McCarran-Ferguson Act was clearly wrong as a matter of law. The Nonprofit Hospital Plan Act exempts Blue Cross from the application of the insurance laws of the Commonwealth unless the particular statute specifically refers and applies to such a corporation: 40 Pa. C.S.A. 6103(a). Accordingly, unless the anti-trust aspect of insurance was prescribed by statute, the McCarran-Ferguson Act exemption was inapplicable: *F.T.C.* v. *National Casualty Co.*, 357 U.S. 560 (1958).

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1. 15 U.S.C.A. 1012.

The only regulation of the anti-trust aspect of the insurance business in Pennsylvania when *Travelers* was decided[1] was the Act of June 5, 1947, P.L. 445, 40 P.S. 1151, et seq., which Act applied generally to insurance business but did not encompass Blue Cross activities because Blue Cross was not specifically included thereunder as required by the Nonprofit Hospital Plan Act. There was therefore no regulation at the state level of the anti-trust aspects of Blue Cross activities as required by the McCarran-Ferguson Act to be eligible for the exemption from the Sherman Anti-Trust Act.[2]

That there was no state action to exempt these provisions from Federal anti-trust scrutiny was held in the first *Travelers* case, *Travelers Insurance Company* v. *Blue Cross*, 291 F. Supp. 1109 (1969), wherein the Court stated:

> " . . . No case cited by the parties nor discoverable through extensive research reveals any authority ascribing 'state action' immunity either to a private entity or to the transactions of a state agency which were not mandated or directed by legislative enactment. That regulation and supervision alone do not constitute a delegation of governmental authority is well established (citations omitted) . . . the Pennsylvania Non-Profit Hospital Plan Act is completely silent in matters that have to do with restraint of trade . . . Blue Cross fails to meet the standards inherent in a 'state action' exclusion from the scope of the Sherman Act . . . and it has not been extended valid governmental authority to engage in anticompetitive practices . . . "

Anti-trust is not an issue in this case. The lack of state anti-trust regulation was not raised in *Travelers*. The matter is discussed here because of the continued reliance on *Travelers* to sustain the refusal of Blue Cross to pay its

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1. By Act of July 22, 1974, P.L. 589, 40 Pa. C.S.A. 1171.1, et seq., Blue Cross has now been expressly included in Pennsylvania anti-trust regulation.

2. 15 U.S.C.A. 1, et seq.

share of the cost of community services. Such refusal cannot be sustained as mandated, since there is no power to mandate in the Insurance Commissioner. It cannot be sustained as part of a rate regulatory scheme since there is no regulation of rates of payment to hospitals, merely a right to approve or disapprove. It cannot be sustained by citing *Travelers*, since *Travelers* involved anti-trust and was in error even in the anti-trust field. Hospitals are not a rate regulated industry, and the Lower Court erred in relying upon such regulation as the basis for remedial legislation.

CONCLUSION

Judge Luongo, in the dissent below, recognized the confiscatory nature of the rates imposed on hospitals by Act No. 94 during the thirteen-month period if no new contract is finally negotiated. The failure of these rates to include a proportionate share of real cost to operate a hospital constitutes state imposition of rates at less than costs.

The community services performed by hospitals must be paid for by the community. As a matter of public policy, Blue Cross subscribers should carry their share of this community need. This is particularly so since such subscribers constitute the greatest part of the population able to pay for medical care.

If real costs are accepted as costs, and hospitals are being required to operate at less than cost, it is clear that Act No. 94 takes property without compensation in violation of the Fourteenth Amendment to the Constitution and abridges substantive contractual rights in violation of the Contract Clause.

There can be no justification of Act No. 94 as being part of a regulatory system governing hospital rates, first because rate regulation would not justify a requirement to operate at less than cost, and second because hospital rates and rates of payments by Blue Cross to hospitals are not regulated or fixed. The latter need only to be approved.

It is respectfully submitted that Act No. 94 is unconstitutional and that the order of the Lower Court should be reversed.

Respectfully submitted
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TABLE OF CITATIONS

Cases:	Page
Denver Union Stock Yard Co. v. *U.S.*, 304 U.S. 470 (1938)	17
D. C. Transit System Inc. v. *Washington Metropolitan Area Transit Commission*, 466 F.2d 394, cert. denied, 409 U.S. 1086 (1972)	17
Frankfort Hospital v. *Greater Philadelphia Blue Cross*, No. 76–2049, before the Third Circuit Court of Appeals	
FTC v. *National Casualty Co.*, 357 U.S. 560 (1958)	25
Guest v. *Fitzpatrick*, 409 F. Supp. 818 (E.D. Pa. 1976)	20
Home Building and Loan Association v. *Blaisdell*, 290 U.S. 398 (1934)	17, 18
Louisville Joint Stock Land Bank v. *Radford*, 295 U.S. 555 (1935)	17, 18, 19
Pennsylvania Insurance Department v. *St. Luke's Hospital*, 21 Pa. Commonwealth Ct. 10, 342 A. 2d 773 (1975)	22
U. S. Rys & Elec. Co. v. *West*, 280 U. S. 234 (1930)	17
Travelers Insurance Company v. *Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), aff'd. 481 F.2d 80 (3d Cir. 1973), cert. denied, 414 U.S. 1093 (1974)	24, 25
Travelers Insurance Company v. *Blue Cross of Western Pennsylvania*, 291 F. Supp. 1109 (1969)	2, 25, 26
W. B. Worthers Co. v. *Kavanaugh*, 295 U.S. 56 (1935)	17, 18, 19

Federal and State Statutes:	
Act of July 22, 1974, P.L. 31, 40 Pa. C.S. §1171.1	5, 25
Act 94, Act of August 2, 1975, P.L. ____ Act 94, 40 Pa. C.S. §6101	1, et seq. 8
Nonprofit Hospital Plan Act, June 21, 1937, P.L. 1948, 40 P.S. §1401, repealed, and replead Act of November 15, 1972, P.L. 1063, 40 Pa. C.S.A. 6101, et seq.	22, 25
Social Security Act, Title XVIII, 40 U.S.C. §1395 X(v)(1)(A)	9

TABLE OF CITATIONS (Continued).

Statutes:	Page
Public Welfare Code, Act of April 9, 1929, P.L. 177, *as amended*, 62 P.S. 901	20
Reorganization Plan No. 2 of 1973, 71 P.S. §755–2	20
Act of July 15, 1976, P.L. ____ (No. 202) amending section 443.1 of the Public Welfare Code	11
Sherman Act, 15 U.S.C. §1	25
McCarran-Ferguson Act, 15 U.S.C. §1012	24, 25
Act of June 5, 1947, P.L. 445, 40 P.S. §1151, et seq.	25
Hill-Burton Act, 42 U.S.C.A. 291, et seq.	11
Constitution:	
Fourteenth Amendment to United States Constitution	
Miscellaneous:	
Factors Affecting the Costs of Hospital Care, Blakiston Co., Copyright 1954, published by Maple Press Company, York, Pennsylvania	7